CALIFORNIA DEPARTMENT OF INSURANCE
Response to Public Comments
SB 853 - Health Care Interpreter Regulations
2nd Comment Period
Ending 11/9/2006

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1	**Marty Martinez Asian & Pacific Islander American Health Forum, et. al.**	**Decline**	**Sections 2538.2(i); 2538.3(c); 2538.4(a); 2538.5(b)(2); Multiple Languages and Notice Produced by DOI** **Issue:** The term "Multiple Languages" was deleted throughout the document. We strongly supported the requirements in the initial proposed regulations that the needs assessment surveys and notices of free interpreter services be provided in "multiple languages," and are disappointed that all references to "multiple languages" have been removed. Under SB 853, each and every enrollee is entitled to interpreter services regardless of whether their language is a threshold language, and these individuals need to be informed of that right and have notice of the right to interpreter services. The statute also has a separate requirement that requires health insurers advise limited-English proficient insureds of the availability of interpreter services. Since there are no thresholds for the provision of interpreter services, the notice must be provided in as many languages as DOI determines necessary. **Recommendation:** We suggest that health insurers be required to verbally inform (possibly through a telephone call) or provide written notification to each insured in his/her primary language. The regulations should also specify that health insurers develop and display outreach materials in multiple languages of an insured's right to language assistance services and the process for accessing these services at physician's offices and health care facilities where their insured are	"Multiple languages" has been deleted from the regulations for lack of statutory authority. While the requirement for notice in "multiple languages" has been deleted, in order to address the serious issue of LEP insureds receiving notice of the availability of interpretation services in a language that they can understand, the Commissioner has amended the regulations to provide for a notice to be developed by the Department which insurers shall provide to all insureds. It is the intention that this notice shall be written in multiple languages. We are in agreement with the commenter that there are different requirements in SB 853 for translation of written documents and oral interpretation services. In order to accomplish the goal of every insured being notified of their right to interpretation services, the Commissioner determined that the Department would develop a 'notice' in multiple languages which all health insurers are required to send to their insureds informing them as to their method of accessing their language assistance services.

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			served. In §2538.3(c), it is implied that DOI will develop a general form letter translated into several languages for insurers to distribute. This is not a sufficient means of informing each insured of their right to language services. We are concerned that a single generic form letter will not fully inform consumers of their rights and appropriate process to access the services of each insurer. <u>Specifically, we urge you to include the definition and references to "multiple languages" in the final regulations and adopt the following language</u>: §2538.3(c). Health insurers shall verbally inform each new and renewed insured about the availability of language assistance services in his/her primary/preferred language and how to access those services or provide written notice about the availability of free language assistance services to all new or renewed insureds. Health insurers shall develop a written notice that discloses the availability of language assistance services to insureds and explains how to access those services in their primary/preferred language. A copy of this notice shall be included with all vital documents and all new and renewing insured welcome packets or similar correspondence from the health insurer confirming a new or renewed enrollment. The notice described above shall be translated into multiple languages [or into the top ten non-English languages identified	

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			by the insurer as the most likely to be encountered among its insureds] and displayed in network offices, including physician offices and health care facilities where their insureds are served; however, nothing in this section shall prohibit an insurer from translating the notice into additional languages. Health insurers shall also provide LEP insureds with language identification cards, and maintain a 24 hours per day, 7 day per week toll free telephone line that insureds and providers may call to obtain the insurer's assistance in arranging language assistance services. The Commissioner may develop a notice advising LEP insureds of the availability of language assistance services and how to access those services. Health insurers shall provide the notice developed by the Commissioner to their insureds on an annual basis. This notice shall be filed and approved with the Department of Insurance prior to use.	
		Decline	**Sections 2538.1(b); 2538.2(f) Deletion of References to Cultural Competency** **Issue:** We are concerned that in **§2538.2 (f),** the term 'cultural needs' is deleted. In addition, at §2538.1(b) the term 'culturally competent' is deleted in defining oral interpretation services. As explained in our prior comments and by other experts, cultural competence is an important aspect of ensuring that language services are provided. Moreover, SB 853 requires DOI to use various sources as a guide to establish standards; all of these sources cite cultural competence as an essential component to ensuring the quality of language services.	While "culturally competent" has been deleted from the regulation, "taking the cultural and social context into account" has not. The legislative history cited specifies the concept of "cultural competence" only. This term has been removed. The remaining uses of the words 'culture' or 'cultural' are descriptive with respect to a part of the remaining regulation.

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			Recommendation: While we appreciate your recognition of the importance of ensuring cultural competency in other sections, we strongly urge you to incorporate the deleted references to cultural needs and cultural competency back into in the final regulations.	
		Decline	**Section 2538.6(c): Use of Family, Friends and Minors as Interpreters** **Issue:** In **§2538.6 (c),** the provision regarding the use of family, friends and minors as interpreters has been changed. The intent of the statute is that a qualified interpreter is to be used in all encounters with an LEP patient. We believe that it would be more useful if this section explained the limitations of using ad hoc or untrained interpreters, such as family, friends and minors in the context of requiring the use of qualified interpreters. The regulations, unfortunately, do not specifically require the use of "qualified" interpreters, and allows the use of family, friends and even minors, as the section only "strongly discourages" their use. As explained in our prior comments regarding the inappropriateness and dangers of using family, friend, and especially minors as interpreters, their use should not generally be allowed. However, we understand that there may be limited circumstances, such as in cases of emergency or if the LEP patient requests it, where their use may occur. It was the intent of the co-authors of the legislation to define an emergency situation as one when a patient is in a life-threatening situation and there is no available	The Commissioner has modified the language to delete "prohibited" and insert "strongly discourage" regarding the use of minors as interpreters. Clarifies the distinction between the use of a minor in an emergency and non-emergency situation. This change was made to ensure that an adult insured would have access to interpretation if their only choice, after being offered a qualified interpreter at no cost, is to use a minor as an interpreter.

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			interpreter other than a family member, including a minor, or friend. We are concerned that **§2538.6 (c)(2)** may cause some confusion as to when a minor can be used because it would further restrict the use of minors in emergency situations, yet allow it in non-emergency situations. It is doubtful that any minor would have the ability to interpret complex medical information. If a qualified interpreter is available, or it is at all possible to find one, the qualified interpreter needs be used. All LEP patients should automatically be informed that a qualified interpreter is available at no cost before being prompted by any request by the LEP patient. **Recommendation:** The regulations must clearly define that the use of a minor as an interpreter should only be used in life-threatening emergency situations. We prefer the prior language that prohibits the use of minors unless there is an emergency and only until an adult interpreter becomes available. We continue to believe that minors should be banned from serving as an interpreter in non-emergency situations. It is bad medical practice and destructive to the minor. The regulations should also state that in situations in which insureds insist that minors be present during the medical encounter and assist in the interpretation process, that a qualified, independent interpreter must also be present to ensure the appropriateness of the interpretation. Finally, any interpreter, including family members and friends must "demonstrate the ability to interpret complex medical	

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			information in an emergency/critical situation" or in a non-emergency situation.	
		Decline	**Section 2538.6(c)(2): Use of Minor in Emergency** Specifically, we recommend the deletion of §2538.6 (c)(2) and replacing § 2538.6 (c) with the following language: **§ 2538.6 (c)** Every health insurer shall develop policies and procedures to provide qualified interpreting for all LEP insureds, in their primary/preferred spoken language, at no cost to the LEP insureds at all points of contact where language assistance is needed. The use of ad hoc or unqualified interpreters, including friends and family members, especially minors, under the age of 18, as interpreters is prohibited except in the case of a medical emergency when time is of the essence, a life-threatening situation, and when no qualified interpreter is available, or if the enrollee insists on using a family member or friend. A minor shall only serve as an interpreter until a qualified adult interpreter becomes available. The enrollee must first be informed that a qualified interpreter is available at no charge to the enrollee. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured's decision to use the adult family member or friend as the interpreter shall be documented in the medical record and/or health insurer file. It is advisable that the insurer and/or provider use its own qualified interpreter to assure the accuracy of the interpretation and that no breaches of confidentiality occurs.	The statute is silent regarding the details of "individual access to interpretation services". In order to effectuate the purpose of this statute, it is necessary to describe in detail some of the issues that are key to providing this service to LEP insureds such as the use of minor children as interpreters. The development of policies and procedures as proposed in these regulations is a quality assurance measure that will protect individuals, including minor children, from the negative consequences and adverse effects of being inappropriately used as interpreters for patients seeking emergency and non-emergency medical services. The Commissioner has carefully considered the various opinions and positions regarding this issue and has determined that the use of minors as interpreters should be strongly discouraged but not prohibited.

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		Decline	**Section 2538.3(b): Staff Training** **Issue:** We are pleased that you have added specific language requiring, at a minimum, the four elements of a language assistance program in §2538.3 (b), but believe that additional guidance is needed with regard to staff training. Offering training to all relevant personnel would ensure proper implementation of the Language Assistance Program and would enhance the services offered. The regulations are silent on this issue. **Recommendation:** We recommend the adoption of the following language: (A) Every health insurer shall implement a system to provide adequate and on-going training regarding the insurer's language assistance program to all staff. The training shall include instruction on: (1) Knowledge of the insurer's policies and procedures for language assistance; (2) Working effectively with LEP persons; (3) Working effectively with in-person and telephone interpreters; and (4) Cultural differences and diversity of the insurer's enrollee population. (B) Staff training should be conducted as part of the orientation for new	Staff training is a required element of an insurer's Language Assistance Program. The Commissioner has determined that health insurers will benefit from flexibility in how they arrange for and provide the 'staff training', therefore, this section provides general guidance rather than specific requirements.

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			employees, where possible, or within a short period of time after employment begins. For current employees, such training should occur within ninety days of implementation of the system by the insurer. Training is to be held at regular intervals as needed to keep staff up-to-date. (C) Training shall be provided to all staff, including all individuals who have routine contact with LEP persons, individuals who may come into contact with LEP members, and all managerial and supervisory staff. Management staff must be trained so they are fully aware of and understand the insurer so they can reinforce its importance and ensure its implementation by staff.	
		Decline	**Section 2538.2(d) Deletion of References to Sign Language Interpretation** **Issue**: We are concerned about the deletion of references to sign language interpretation throughout the document. We believe that it is critically important that the needs of communities with disabilities must be addressed in every regulation. **Recommendation:** We recommend that the final regulations restore language related to sign language interpretation and signing.	"Sign language" has been deleted from these regulations because there is no statutory authority to include 'sign language'. The intent of SB 853 was to provide language assistance to limited English proficient insureds.

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		Accept in concept.	**Section 2538.2(o) Vital Documents** **Issue:** Because the right to file a complaint or appeal would be meaningless unless the complaint or grievance form is translated into a language that the complainant could understand, the vital document definition should include the complaint or grievance form to be filed by the insured if any problems arise. **Recommendation:** In addition to notices pertaining to the right to file a complaint or appeal, the actual complaint or grievance form should be listed as vital documents. Specifically, we recommend the adoption of the following language: "§2538.2 (4) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a complaint or appeal, including the complaint, grievance, and/or appeal form."	We believe that the current language of this subsection would require the translation of the form to be filed for a complaint because the language states: "Notices pertaining to…and the right to file a complaint or appeal;" and the form to be filled out by the complainant "pertains" to the right to file a complaint or appeal.

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2	**Anne Eowan** **Assoc. of California Life & Health Insurance Companies (ACLHIC)**	**Decline**	**SECTION 2538.2 DEFINITIONS** **(1) Language(s) Definitions Lack Clarity / Authority.** Subdivision (b) establishes a definition of "indicated/threshold languages" as those languages identified pursuant to Section 10133.8, and the regulations. Both the statute and the regulations (Sec. 2538.4 (a)) require insurers to survey the language "preferences" of their insured population. Subdivision (c) has been revised to add a new, undefined term, i.e. "primary/preferred language." There is no reference in the statute for a primary language, only a preferred language that is, in fact, the threshold language defined under (b). The two terms could be mutually exclusive. An insured's primary language could be Spanish, yet they might prefer their documents in English. The regulations should be **clarified** to strike "primary" and incorporate "preferred" under the definition of "indicated/threshold languages" and in other areas where "primary/preferred language(s)" appears in the text.	
		Decline	Also, it appears that the term "indicated/threshold language" should be substituted for the term "target language" in subdivision (d), and Section 2538.5 (d).	This would change the meaning of the provision in these regulations and therefore is not changed.
		Decline	**(2) Inconsistent Use of Terms "Cultural" and "Social Needs."** Subdivision (f) strikes the requirement that the language preference and linguistic needs assessment, (and thus all documents and services relating to that assessment), include an assessment of cultural needs of the insured population. We agree that this is consistent with statutory requirement and appreciate this change. However, the revised text does not strike this term consistently throughout the document. For example, subdivision (d) requires that interpretation incorporate	While "culturally competent" has been deleted from the regulation, "taking the cultural and social context into account" has not. The legislative history cited specifies the concept of "cultural competence" only. This term has been removed. The remaining uses of the words 'culture' or

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			the cultural and social context of a person's "target" language, while Section 2538.1 (b) strikes the requirement that oral interpretation be culturally competent. Section 2538.5 (c) then requires health insurers to submit a written request to the Commissioner detailing, among other things, how insureds will be receiving culturally competent health care. Thus, for **consistency** and **clarity**, all such references should be stricken.	'cultural' are descriptive with respect to a part of the remaining regulation.
		Decline	**(3) Benefit Matrix Lacks Authority.** Subdivision (e) adds a new requirement to those "vital" documents that must be translated into threshold languages. Specifically, subsection (7) requires an insurer to develop, and translate, a matrix of benefit categories, which must include specified information in a specified order. The authority cited is Section 10133.8, but there is no authority to require such a matrix in that section, nor is there any authority mentioned in the OCR Guidance that may also be relied upon in that code section. In fact, ACLHIC is not aware of this requirement anywhere else in statute applicable to health insurers. Instead, the legislature specifically did not require health insurers to develop a benefit matrix. Health insurers were excluded from the statute requiring health care service plans to provide a benefit matrix for individual and small group coverage (see AB 607 - Scott, Chapter 23, Statutes of 1998). Subsequent legislation (AB 1596 - Frommer, Chapter 164, Statutes of 2004) only required health insurers to provide a downloadable copy of a Department of Insurance comparative matrix for individuals leaving the Managed Risk Medical Insurance Program and entering into specific guaranteed issued products in the individual market. These are the only two statutes ACLHIC is aware of that require benefit matrices, and as mentioned, neither require health insurers to develop such a matrix. Thus, ACLHIC must question the **authority** cited by the Department to require such a benefit matrix to be developed, and translated,	This requirement is authorized by California Insurance Code section 10133.8(b)(3)(B)(iii) that states, "Letters containing important information regarding eligibility or participation criteria" are vital documents required to be translated by the insurer. This is probably the single most important document for the insured. It provides an easier to understand layout of exactly what the insurance plan covers and does not cover. It supplies exactly what the insured's out of pocket payments will be for different types of services. In insurance, this is the lifeblood of benefits documents typically distinguishing between preventive, restorative and major procedures which are typically covered by the plan at different co-insurance levels. This matrix of benefits document would be even more crucially important in limited benefit plans since it would put consumers on notice of exactly which benefits are NOT covered.

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			applicable to all markets – individual, small and large group business, and therefore request that the benefit matrix requirement be stricken. However, ACLHIC concurs with the striking of "individual insurance policies and certificates of insurance" from subsection (4), for the reasons cited in our September 25th comment letter.	
		No response needed.	**(4) <u>Other Definitions</u>.** ACLHIC agrees with, and appreciates, that the definition of "multiple languages" in subdivision (i) has been stricken here, and throughout the text, and replaced with "threshold languages." We agree that this change is consistent with statutory intent and authority.	Commenter supports change in regulations found in the revised text.
			<u>SECTION 2538.3 LANGUAGE ASSISTANCE PROGRAM</u>	
		No response needed.	**(1) Implementation Timeline Lacks Authority / Consistency.** This section makes it clear that the Department expects insurers to have implemented completely their LAP by January 1, 2008. In our September 25th letter, ACLHIC requested that the effective date of implementation of an insurer's LAP be consistent with the proposed Department of Managed Health Care's companion regulations on this topic by extending the implementation date to January 1, 2009.	This comment is not responsive to the changes made to these regulations by the revised text. Section 2538.3 (b), (c), and (d) were amended. The language regarding the implementation date was not changed in the revised text.
		Decline	**(2) Lack of Clarity / Authority Regarding Commissioner Notice.** Subdivision (c) has been amended to require health insurers to translate the required notice in the threshold languages, not multiple languages, and ACLHIC concurs with this change. However, additional language has been added authorizing the Commissioner to develop a notice, that insurers would also have	The regulation is permissive " The Commissioner *may..*" The Commissioner has broad authority under Section 10133.8 (a) to adopt regulations to implement this statute and something as minor as a State notice to be passed on to

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			to send out to insureds on an annual basis. It is not clear what **authority** the Commissioner is relying on, since the statute requires insurers, not the Department, to develop such a notice. Further, it is not **clear** what languages the notice will be translated into. If the notice includes languages that are not threshold languages as identified by a particular insurer, the insured could easily be misled into assuming that the insurer will provide translation services in those languages. Clearly, this is not the case. Since such a notice will be **duplicative**, potentially **misleading** and require an expensive annual distribution requirement that is **not authorized** by statute, ACLHIC asks that this entire provision be stricken.	insureds advising them of their rights to language assistance does not require a specific statutory mandate.
		Decline	**(3) Lack of Statutory Authority to Require Contracting Providers or Contracting Agents to Implement the Law.** Subdivision (d) requires that health insurers include in their contracts with their providers provisions that the health provider comply with the Language Assistance Program. The statute authorizing the regulations does not include any requirements regarding private contracts between providers and the health insurer. The Department will note that the authorizing statute, SB 853 (Escutia, 2003) specifically requires health care service plans regulated by the Department of Managed Health Care to include provisions in provider contracts to ensure compliance (Section 1367.04 (f) of the Health and Safety Code), but the statute specifically does not include a parallel section in the Insurance Code relating to health insurers. This was by design at the time of passage of SB 853, because it was recognized that an insurer would have no way of ensuring that requirements were being met contractually, since open network plans, such as PPOs, do not require an insured to seek services first through a primary care physician who could monitor compliance with this requirement. Further, insureds can seek care through both	Health insurers who directly contract with providers or lease networks of providers shall amend their contracts with providers and networks "as needed" to implement their LAP. The Commissioner has built in flexibility for health insurers regarding how they implement their LAP.

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			a contracted and non-contracted physician. The revisions to this subdivision greatly exacerbate this problem by requiring insurers that simply lease a network of providers, to require the contracting agent to then amend all their contracts with providers to include provisions that each provider meet the specific LAP criteria of each of their individual insurer clients. Again, this is **inconsistent** with the statute and legislative intent for the reasons stated below. There are no provisions that require provider contracts to be amended, nor does the statute authorize the Department to impose new requirements on contracts with contracting agents. Instead, the onus is on the insurer to meet the LAP criteria. ACLHIC cannot underscore enough that these revisions are completely unenforceable on the part of the insurer. Contracting agents simply develop networks of providers who have agreed to discounted rates, and then lease those networks to other clients, such as insurers. A contracting agent will not go back and amend all those provider contracts to include all the LAP provisions of each of their clients. This would be prohibitively costly and require individual negotiations with each provider regarding each of the LAP provisions. A contracting agent would not agree to such an imposition. The result will be severe provider network disruptions and limitation of provider choice for insureds, since the only recourse an insurer would have would be to cancel the contract with the contracting agent. Thus, this new revision is not only unenforceable, but potentially disastrous to the integrity of an insured's provider network.	

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		Decline	**SECTION 2538.4 NEEDS ASSESSMENT OF INSURED POPULATION** **(1) Requirement to Survey Each Individual Insured Inconsistent with Statute / Lacks Authority.** The regulations as revised now require that each health insurer survey the language preferences and linguistic needs of "each insureds." On further review of the overall statute, we feel very strongly that the statute did not require each individual insured to be surveyed. The fact that "each" (singular), as added to the revised regulations, modifies the plural "insureds" as stated in the statute underscores the legislative intent that "insureds" was meant to be plural rather than singular. Further, the statute envisions survey methodologies which do not contemplate contacting each individual insured, which could be several in each household. For example, the statute authorizes the use of newsletters and other mailings, (Section 10133.8 (b)(2)) which may go to an employer for distribution to employees, or to the subscriber only. The statute further grants insurers flexibility under Section 10133.8 (c) (8) and (9) to implement the requirements of the law in a cost-effective manner. In fact, the OCR Guidance referenced in (C)(3)(b) states that "A recipient/covered entity assesses language needs by: identifying the non-English languages that are likely to be encountered in its program and by estimating the number of LEP persons that are eligible for services…This can be done by reviewing census data, client utilization data, data from school systems and community agencies and organizations." 10133.8(b)(2) provides that insurers may use various survey methods "including but not limited to…" Thus, requiring that each individual insured is surveyed and assessed goes	The statute requires "individual access to interpretation services" by insureds in accessing health care. The insured group is made up of individuals. Each of these individuals speaks a language. For purposes of the needs assessment as well as providing language assistance, the insurer may not assess the needs of the "group" to the arbitrary exclusion of certain individual insureds. The Legislative intent was to make sure that each insured's language needs be included in the insurer's needs assessment. The Commissioner has provided flexibility in the regulations for insurers to survey using a variety of methods, however, without individual language preferences being known, appropriate individual interpretation services will be difficult to provide. Some insurers are already including in their policies a statement regarding access to language assistance services.

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			beyond statutory **authority** and is **inconsistent** with the other provisions of the law. We ask that the regulations be clarified to allow survey methodologies that are not limited to surveys of individuals.	
			SECTION 2538.6 INDIVIDUAL ACCESS TO ORAL INTERPRETATION SERVICES	
		Decline	**(1) Definition of "Timely" Interpretation Services Creates an Unenforceable, Unclear Standard.** ACLHIC concurs with the standard for "timely" interpretation services as originally included in Subdivision (a) of this section of the proposed regulations; namely, that oral interpretation services must be provided in a manner appropriate for the situation. This allows for full regulatory oversight of individual situations to ensure the statute is being met. The revised regulations add this additional language to the regulations: "Interpreter services are not timely if delay results in the effective denial of the service, benefit, or right at issue of the imposition of an undue burden on or delay in important rights, benefits, or services to the LEP insured." This creates an **unclear** standard, i.e. what is an undue burden? What are "important" rights? ACLHIC is very concerned that this will only lead to litigation, while not adding anything to the Department's ability to enforce what it determines to be the provision of services in a manner appropriate for the situation. ACLHIC requests that the added language be stricken.	This sentence was added to clarify the meaning of timely access to interpretation services in the sentence that precedes it. By necessity, the question of what constitutes a delay will always depend on the specific circumstances of each patient and provider encounter where language assistance is needed and delay may be judged differently by a provider than a patient. Without this language, the meaning of timely access is not clear. Timely standing alone would be subjective and truly mean different things to insureds. It is essential to define what circumstances e.g. denial of service, benefit or right or the imposition of an undue burden etc constitute an untimely delay. It would be unreasonable and impossible to list all of the specific circumstances constituting untimely delay in interpreter services and as such there will always be a subjective element to these situations.
		Decline	**(2) Revised Criteria Regarding the Use of Family, Friends and Minors as Interpreters Lacks Clarity / Authority.** ACLHIC concurs with the first revisions to Subdivision (c), which remove the outright prohibition against the	The purpose of adding the intent regarding the use of family members and friends language in this section is because a

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			use of a minor, and instead discourages such use. We appreciate this change. However, we continue to raise concerns that setting any standard regarding family and friends interpreting for an insured is **outside the statutory authority** of the law. The revised text that follows in this subdivision would set standards for the use of family and friends in non-emergency situations, and minors in emergency situations. Specifically, the revisions require that an insured be <u>fully</u> informed of the availability of an interpreter in their primary/preferred language. Again, "primary/preferred language" is not defined in the regulations. This term should be changed to "indicated/threshold language" which <u>is</u> defined. Further, what does "fully" mean? How is that enforceable? Second, the refusal of these offers must be documented in the medical file. How would an insurer, who gets a claim after the fact, even know if an offer was made and refused, unless the insured advises them? As we indicated in our September 25th letter, insurers are required to develop a notice in the threshold language and devise other methods of advising the insured of their right to interpreter services. Thus, the insured should already know, before they access services, what those rights are and how to access them. Trying to enforce this on doctors to "fully" advise and note refusals in medical records would place an undue burden on providers and expose insurers to litigation and punitive enforcement actions for something they could not control. We reiterate our comments earlier in this letter that the <u>statute specifically excluded a requirement that provider contracts require implementation</u>. We appreciate the fact that the Department is attempting to find some workable	major change was made in the second revision of these proposed regulations allowing minors as interpreters. Many commenters oppose this provision for a variety of quite valid reasons. There are many situations where minors cannot do a competent job of language interpretation due to the complexity of the terminology or if the minor is negatively affected emotionally by the situation of the LEP insured. The added " intent" language balances the accommodation of minors as interpreters with the best practices goal of using qualified adult language interpreters.

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			solution to this issue, but recommend that the Department strike subsections (1) and (2) of subdivision (c) in this section. We also reiterate the need to strike the requirement that interpreters demonstrate sensitivity to an LEP person's culture in subdivision (d), **consistent** with the striking of "culturally competent" oral interpretation in Section 2538.1 (b), and in Section 2538.2 (f).	
		Decline	**SECTION 2538.7 HEALTH INSURER MONITORING, EVALUATION AND REPORTING** **(1) Monitoring of Network and Provider Compliance Lacks Authority.** ACLHIC reiterates our concern stated earlier in this letter that the statute specifically excluded any provisions requiring insurers to enforce the implementation of the law through provider contracts. Further, the revisions that add a requirement that networks of providers also be monitored, whether leased or not, **exceeds statutory intent and authority.**	
		No response needed.	**SECTION 2538.8 DEPARTMENT OF INSURANCE REPORTING** **(1) Implementation Timeline Lacks Authority.** The revisions to this section make it clear that the Department expects insurers to have implemented completely their LAP program by January 1, 2008 in order for the Department to recommend changes to "forms" used by insurers in their LAP. We reiterate our objection on the basis that the statute authorized a full year for insurers to complete the first phase of that implementation, namely, the needs assessment. Please see our comments earlier in this letter regarding the implementation timeline for the LAP under Section 2538.3.	

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		Decline **No response needed.**	**(2) Lack of Clarity Regarding the Development of "Forms."** The revisions also state that the Commissioner will make recommendations for insurers to make changes in their LAP, including the development of "forms." We are unsure what these forms are, since the statute only requires the development of a notice. We ask for **clarity** here. **REMAINING CONCERNS** As mentioned several times in this letter, ACLHIC recognizes the obvious effort on the part of the Department to address many of the issues raised in our September 25th letter on the regulations as originally proposed. While we are aware that the Department is under no obligation to comment on issues not related to the revised text, we would like to simply point out those areas for which we continue to have a concern. Those concerns are clearly explained in our September 25th letter, for reference. Those remaining concerns are: (1) The definition of "Points of Contact" should be clarified. (2) The requirement that oral interpreters "demonstrate" a documented proficiency goes beyond statute and would be difficult to comply with. (3) There is no recognition that limited benefit plans, such as vision-only or dental-only, would not have the resources to comply at the same level as a comprehensive health plan. We have offered several alternatives, and ask for some flexibility for these plans. Also, the Department of Managed Health Care's proposed regulations do provide some flexibility for these types of products, which would lead to a competitive disadvantage for those limited benefit	This comment does not address the revisions to the text of these regulations.

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			products that are regulated by the Department of Insurance. We ask that the Department consider amending the regulations accordingly.	This amendment is in response to those commenters who were concerned about developing a 'form' to notify insureds about their LAP. The Commissioner has on several occasions developed the notices/forms that are required by statute, thus avoiding the difficulty of different forms being developed by each insurer. These comments are not responsive to the revised text of the regulations.
3	**Armand Feliciano Blue Cross Life & Health Ins. Co.**		**I. Although CDI deleted culture from the "Authority and Purpose" section of the regulation, it must strike all references to culture in the regulation because they lack statutory authority.** Based on SB 853's legislative history, the Legislature intended to exclude cultural factors from the regulation requiring health insurers to provide language assistance. We specifically cite SB 853 as amended on September 4, 2003, whereby "and culturally competent health care services, as appropriate" was stricken from the requirement that CDI develop standards to provide insureds with appropriate access to translated materials and language assistance. In that same version of SB 853, the "operational definition of cultural competency" was also expressly deleted from the bill. Furthermore, we believe that "culture" is sufficiently unclear because it could have more than one meaning. We,	The legislative history cited specifies the concept of "cultural competence" only. This term was removed when revised. The remaining uses of the words culture or cultural are descriptive with respect to a part of the remaining regulation.

#	Person Submitting Comment	Action Taken	Summary of Comments/Issues Submitted	CDI Response
			therefore, suggest the following deletions below:	
		No response needed.	§ 2538.2-Definitions (d) "Interpreting" or "interpretation" means the process of listening …, and orally re-expressing that message faithfully, accurately and objectively in another spoken …, ~~taking the cultural and social context into account.~~	The revised text of this section clarified the meaning of interpreting; it did not change the language addressed here. Therefore, no response is required.
		No response needed.	§ 2538.3- Language Assistance Program (b) (6) Provision of adequate and ongoing training regarding the LAP for all staff who have contact with LEP persons. The training shall include instruction on …, ~~and cultural differences among and diversity of the health insurer's insured population~~;	The text of this section was not amended by the revised text. Therefore, no response is required.
		No response needed.	§ 2538.5- Written Translation of Vital Documents (c) Health insurers may implement the translation of vital documents in phases by submitting a written request to the Commissioner detailing their plan, timeframe, rationale and projected impact on the receipt of ~~culturally and~~ linguistically competent health care by insureds.	The text of this section was not amended by the revised text. Therefore, no response is required.
		Accept	§ 2538.6- Individual Access to Oral Interpretation Services (b)(4)(C) Contracting with outside interpreters ~~including certified sign language interpreters;~~	This language has been deleted from the revised text of the regulations.
		No	(d) Every health insurer shall develop policies and procedures to ensure	The text of this section was not amended by the revised text.

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		response needed.	the quality and timeliness of oral interpretation services provided to insureds. The policies and procedures shall include mechanisms for ensuring the proficiency of the individual providing interpretation services, including a documented and demonstrated proficiency in the source and target language, ~~sensitivity to the LEP person's culture~~ and a demonstrated ability to convey information accurately in both languages.	Therefore, no response is required.
		No response needed.	§ 2538.7- Health Insurer Monitoring, Evaluation & Reporting (c) Within one year after the health insurer's initial assessment, every health insurer shall report to the Department of Insurance on the implementation of its Language Assistance Program and its internal policies and procedures ~~related to cultural appropriateness~~. **II. The provision allowing the Commissioner to develop a duplicative notice advising LEP insureds of the availability of language assistance services lacks statutory authority and is inconsistent with SB 853.** Upon reviewing the legislative history of SB 853, we did not find any statutory authority for the provision allowing the Commissioner to essentially develop a duplicative notice to inform LEP of the availability of language assistance. Additionally, SB 853 requires the CDI to consider the cost of compliance and to allow for health insurer flexibility in determining compliance. (Ins. Code & 10133.8 (c) (8) (9)). We believe that developing a duplicative notice can add significant costs and is	The text of this section was not amended by the revised text. Therefore, no response is required.

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		Decline	prescriptive. Furthermore, it could lead to frustration among insureds as they try to determine which language assistance services to access when they receive two notices. We, therefore, suggest the following deletion below: §2538.3- Language Assistance Program (c) Health insurers shall develop a written notice that discloses the availability of language assistance services to insureds and explains how to access those services …. ~~The Commissioner may develop a notice advising LEP insureds of the availability of language assistance services and how to access those services. Health insurers shall provide the notice developed by the Commissioner to their insureds on an annual basis.~~ **III. The requirement to provide for notice of language assistance should be modified to minimize the cost of implementation and allow for health insurer flexibility.** As mentioned above, SB 853 requires the CDI to consider the cost of compliance and to allow for health insurer flexibility in determining compliance. (Ins. Code § 10133.8 (c) (8) (9)).” In cases where a health insurer has identified the insured’s preferred language, we think it is cost-efficient to provide the notice that discloses the availability of language assistance services only in the insured’s preferred language. For example, if we are aware that our insured’s primary language is Spanish, then that member should receive the notice only in Spanish. We suggest adding the	The regulation is permissive “ The Commissioner *may..”* The Commissioner has broad authority under Section 10133.8 (a) to adopt regulations to implement this statute and something as minor as a State notice to be passed on to insureds advising them of their rights to language assistance does not require a specific statutory mandate.

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			underlined language below:	
		Decline	§ 2538.3- Language Assistance Program (Add (i) to (c)) (i) If an insured's preferred language is identified, this section shall be satisfied by including the notice only in the insured's preferred language**.**	This language is not responsive to the changes made in the text of the regulations by the revised text. In addition, there is no statutory authority to include this language in the regulations.
			IV. The provision defining an untimely interpreter services lacks statutory authority and is unclear. The final version of SB 853 explicitly requires that the language assistance regulation include "[s]tandards to ensure the quality and timeliness of oral interpretation services provided by health insurers." (Ins. Code § 10133.8 (b)(6)). Based on this, we believe that defining "timely" is appropriate, but defining "untimely" exceeds statutory authority. Furthermore, we believe that the provision defining untimely services includes a phrase that is unclear such as "the imposition of an undue burden …." The imposition of an undue burden is a subjective phrase that will mean different things to our insureds. We, therefore, suggest the following deletion below:	This sentence was added to clarify the meaning of timely access to interpretation services in the sentence that precedes it. By necessity, the question of what constitutes a delay will always depend on the specific circumstances of each patient and provider encounter where language assistance is needed and delay may be judged differently by a provider than a patient. Without this language, the meaning of timely access is not clear. It can be reasonably implied that we are referring to health rights, health benefits and health services in these regulations.
		Decline	§ 2538.6- Individual Access to Oral Interpretation Services (a) Every health insurer shall provide timely individual access to interpretation services at no cost to LEP insureds …. ~~Interpreter services are not timely if delay results in the effective denial of the service, benefit, or right at issue or the imposition of an undue burden on or delay in~~	Timely standing alone would be subjective and truly mean different things to insureds. It is essential to define what circumstances e.g. denial of service, benefit or right or the imposition of an undue burden etc constitute an untimely delay. It would be unreasonable and impossible to list all of the specific circumstances constituting untimely delay in

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			~~important rights, benefits, or services to the LEP insured.~~	interpreter services and as such there will always be a subjective element to these situations.
			V. The word "each" must be stricken from the provision describing the needs assessment of the insured population, and instead, the word "group" must be inserted to be consistent with the purpose of SB 853. In the final version of SB 853, it states "[a] requirement to conduct an assessment of the needs of the insured group." Based on this requirement, it is our interpretation that we have to survey our insureds in a manner that will allow us to obtain an accurate statistical sample of the language needs of our insured group. It is not our interpretation that health insurers have to conduct a survey in a manner that would identify the language needs of each insured as indicated in § 2538.4 (a). In fact, there is ample legislative history to support our interpretation as each amended version of SB 853 reflects assessing the needs of the insured group and not the needs of each insured. We, therefore, suggest the deletion of the word "each," and insertion of the italicized word "the" and "group" as drafted below:	
		Decline	§ 2538.4- Needs Assessment of Insured Population (a) Every health insurer shall survey the language preferences and assess the linguistic needs of ~~each~~ *the* insured *group* within one year of the	The insured group is made of individuals. Each of these individuals speaks a language. For purposes of the needs assessment as well as providing language assistance, the insurer may not assess the needs of the "group" to the arbitrary exclusion of certain individual insureds. We find that the Legislative intent was to make sure that each insured's language needs be included in the insurer's assessment.

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			effective date of these regulations. **VI. The potential liability in the event of a miscommunication should be addressed in the proposed regulation to be consistent with existing law.** As previously raised in other sections, SB 853 requires the CDI to consider the cost of compliance. (Ins. Code § 10133.8 (c) (8)). Under the proposed regulations, health insurers could potentially be sued for any miscommunication that may occur as a result of interpretations conducted by vendors. We believe this falls under the cost of compliance, and therefore request the following underlined language be adopted: § 2538.3- Language Assistance Program (e) Health insurers are not liable for any miscommunication that may occur as a result of interpretations conducted by vendors who meet or exceed the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare.	**Decline** Potential for suit is highly speculative under the circumstances described and we trust that a court of law that might be hearing such an argument in the lawsuit as suggested by the commenter would interpret these regulations in a reasonable fashion.
		No response needed.	**VII. The January 1, 2008, implementation date of the language assistance program needs to be moved to January 1, 2009, to minimize the cost of compliance and allow for health insurer flexibility.** As discussed above, SB 853 requires the CDI to consider the cost of	The text of this section [§2538.3(a)] was not amended by the revised text. Therefore, no response is required. The initial date of compliance is still more than one year away. Many insurers testified that they have long been

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			compliance and to allow for health insurer flexibility in determining compliance. **In sum, a January 1, 2008, implementation date could cost up to $19.5 million.** It is important to note that most, if not all of these costs, are considered administrative costs not medical care. It should also be noted that some of these costs may be passed on to our members. Having laid out all of these cost factors and potential consequences, we urge your agency to move that implementation date to January 1, 2009, as suggested below: § 2538.3- Language Assistance Program (a) By January 1, ~~2008~~, *2009*, every health insurer shall develop and implement a Language Assistance Program (LAP) that complies with the requirements of the Insurance Code sections 10133.8 and 10133.9 and this regulation.	providing language assistance services contemplated in these regulations. In evaluating compliance as of January 1, 2008, the Commissioner may take into account that this date will be the first compliance date under the regulations.
4	**William Barcellona California Assoc. of Physicians Groups (CAPG)**	**No response needed.**	**Regarding section 2538.3(d):** CAPG has serious concerns with the language as proposed. The statute in no way modifies or addresses the California Business & Professions Code, and so thereby the statute in no way empowers the Department any jurisdiction over health care providers or networks. While the statute addresses health plan-provider contracts governed by the California Health & Safety Code, that statutory provision (Section 1367.04(f)) does not in any way apply to health plan-provider contracts government by the	No language was suggested. Health insurers who directly contract with providers or lease networks of providers shall amend their contracts with providers and networks "as needed" to implement their LAP. The Commissioner has built in flexibility for health insurers regarding how they implement their LAP.

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			Insurance Code. Providers or networks must not and should not be required to perform or take on any administrative tasks or responsibilities that are related to a health plan's language assistance program obligations or responsibilities. Providers or networks may do so through separately negotiated arrangements with those Plans obligated to provide the language assistance programs. In this way and as intended by the statute, the Plan then entirely controls and is responsible for the manner and method in which it implements its language assistance program, including how and if its contracted provider network play a role in that program	
		No response needed.	Section 2538.6(c)(2) at page 8 fails to define "an emergency situation," and the phrase "interpret complex medical information" and also "medical record file." This subsection should be limited to "emergency situations" that occur within hospital Emergency Department settings.	
		Decline	We object to proposed section 2538.7(a) because the statute does not amend the Insurance Code in any way that requires providers or provider networks to take part in the health insurer's compliance or monitoring obligations or responsibilities. There is no jurisdiction conveyed under the Insurance Code to regulate providers or provider groups. Again, this is the *insurer's* responsibility and how it does so should be separately negotiated between the insurer and its contracted provider network. There is no need or authority for such downstream regulation.	Unclear as to what action commenter is requesting. Health insurers who directly contract with providers or lease

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				networks of providers shall amend their contracts with providers and networks "as needed" to implement their LAP. The Commissioner has built in flexibility for health insurers regarding how they implement their LAP.
5	**Edmund Carolan California Dental Assoc. (CDA)**	**Decline**	CDA has identified the following areas of the modified text that appear to lack clarity: a) **Section 2538.6 (a)** states that "interpreter services are not timely if delay results in the effective denial of the service, benefit or right at issue or the imposition of an undue burden on or delay in important rights, benefits or Services to the LEP insured. It is unclear to CDA what actually constitutes a delay. In addition, it is unclear what important rights, benefits or services the Department is referencing in this sentence? CDA is also unclear on who will be deciding if an undue burden has been placed on the patient. We remind the Department, as noted in our initial comments, that the authority bestowed on them for the language assistance program is to establish *standards and requirements* (emphasis added) for these programs.	This sentence was added to clarify the meaning of timely access to interpretation services in the sentence that precedes it. By necessity, the question of what constitutes a delay will always depend on the specific circumstances of each patient and provider encounter where language assistance is needed and delay may be judged differently by a provider than a patient. Without this language, the meaning of timely access is not clear. With respect to the comment/question about who will judge the delay as an undue burden or not, a reasonable person standard would apply. The same would be true for what constitutes an important right, benefit or service to the LEP insured would be. It can be reasonably implied that we are referring to health rights, health benefits and health services in these regulations. The purpose of adding the intent regarding the use of family members and friends language in this section is because a major change was made in the second revision of these

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		Decline	b) **Section 2538.6 (c) (1)** states that in a non-emergency situation if the insured requests the use of a family member or friend, the insured shall be *fully* (emphasis added) informed that qualified interpreter services are available'. It is unclear to CDA what is meant to "fully" inform. It is also unclear to CDA whether the requirement to "fully" inform the patient is in addition to the proposed requirement contained in this same section that requires the insured's decision to use a family member or friend be documented in the patient's medical record. In the modified text, the Department is injecting intent language into Section 2538.6 (c) which reads ~'[l}t is the intent of these regulations to discourage the use of family members and friends... It is hard to understand the necessity for such language since it does not make clear a requirement or standard. Furthermore, given that the Department's Initial Statement of Reason states that these regulations are to provide clear and detailed information and instructions related to the development and implementation of language assistance programs, the intent language seems oddly out of place in proposed regulatory language given that is it unclear what requirement the Department is attempting to impose with this statement. Therefore, there does not appear to be a need for intent language in this proposed regulatory language. Furthermore, we believe the provisions of the proposal that incorporate	proposed regulations allowing minors as interpreters. Many commenters oppose this provision for a variety of quite valid reasons. There are many situations where minors cannot do a competent job of language interpretation due to the complexity of the terminology or if the minor is negatively affected emotionally by the situation of the LEP insured. The added " intent" language balances the accommodation of minors as interpreters with the best practices goal of using qualified adult language interpreters. The Commissioner has modified the language to delete "prohibited" and insert "strongly discourage" regarding the use of minors as interpreters. Clarifies the distinction between the use of a minor in an emergency and non-emergency situation. This change was made to ensure that an adult insured would have access to interpretation if their only choice, after being offered a qualified interpreter at no cost, is to use a minor as an interpreter. The statute is silent regarding the details of "individual access to interpretation services". In order to effectuate the purpose of this statute, it is necessary to describe in detail some of the issues that are key to providing this service to LEP insureds such as the use of minor children as

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			intent language will lead to the promulgation of underground regulations and these underground regulations will place additional burdens on dentists.	interpreters. The development of policies and procedures as proposed in these regulations is a quality assurance measure that will protect individuals, including minor children, from the negative consequences and adverse effects of being inappropriately used as interpreters for patients seeking emergency and non-emergency medical services. The Commissioner has carefully considered the various opinions and positions regarding this issue and has determined that the use of minors as interpreters should be strongly discouraged but not prohibited.
6	**Dietmar Grellmann California Hospital Assoc. (CHA)**	**Decline**	**Section 2538.6(c)** continues to exceed the authority granted the Department by SB 853 despite the revised text. There is no statutory authority for the Department to prohibit a minor from interpreting for a patient *when requested by the patient or in an emergency*. The Legislature has chosen not to prohibit minors from providing language services in a hospital or clinic. The Department cannot now exercise legislative powers and accomplish in regulation what the Legislature refused to do in AB 292, AB 775 and in this regulation's authorizing statute, SB 853. Even if there were authority, the regulation is impossible to implement. The Department ignores the fact that in an ***emergency*** situation, life and death decisions in a hospital are made on a moment's notice. There is no	The change requested by this commenter has already been incorporated into the second revised version. The other concerns have been accommodated by the revision already made to Section 2538.6(c) which states the obvious, that nothing in this section is intended to create a barrier to care for LEP insureds. The purpose of adding the intent regarding the use of family members and friends language in this section is because a major change was made in the second revision of these proposed regulations allowing minors as interpreters. Many commenters oppose this provision for a variety of quite valid reasons. There are many situations where minors cannot do a

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			provision made for the situation in which the only interpreter available is a minor, but that minor does not meet the impossible standard in §2538.6(2)(A). Even more nonsensical is the requirement that a qualified interpreter give notice to the patient that interpretation services are available before consent can be given to use a minor: this presumes that hospital emergency departments can provide **instant** interpretation services 24 hours a day, seven days a week, 365 days a year. Emergency and urgent situations often do not allow the luxury of finding a qualified adult interpreter, and the focus is, and must be, on providing immediate life-saving care.	competent job of language interpretation due to the complexity of the terminology or if the minor is negatively affected emotionally by the situation of the LEP insured. The added " intent" language balances the accommodation of minors as interpreters with the best practices goal of using qualified adult language interpreters. The Commissioner has modified the language to delete "prohibited" and insert "strongly discourage" regarding the use of minors as interpreters. Clarifies the distinction between the use of a minor in an emergency and non-emergency situation. This change was made to ensure that an adult insured would have access to interpretation if their only choice, after being offered a qualified interpreter at no cost, is to use a minor as an interpreter. The statute is silent regarding the details of "individual access to interpretation services". In order to effectuate the purpose of this statute, it is necessary to describe in detail some of the issues that are key to providing this service to LEP insureds such as the use of minor children as interpreters. The development of policies and procedures as proposed in these regulations is a quality assurance measure that will protect individuals, including minor children, from

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				the negative consequences and adverse effects of being inappropriately used as interpreters for patients seeking emergency and non-emergency medical services. The Commissioner has carefully considered the various opinions and positions regarding this issue and has determined that the use of minors as interpreters should be strongly discouraged but not prohibited.
7	**Anmol Mahal California Medical Assoc. (CMA)**	**No response needed.** **No response needed.** **Decline**	We very much appreciate the Department's revision to Section 2538.6(b)(5) regarding the use of family members as interpreters. We believe it is now consistent with federal law. We also thank the DOI for adding to Section 2538.2, "Vital Documents" the explanation of benefits (EOB) and a matrix of benefits. These are very important items that every insured should fully understand. We also appreciated the greater detail required in policies and procedures by the insurer under Section 2538.3(b). We would like again to suggest an addition to subsection (2) to require notification of providers on how to access language assistance services of insurers and a similar addition to Section 2538.6. These sections would thus read: §2538.3(b) (2) Notifying contracting providers of the LAP requirements for	Support the revised text of the regulations. Support the revised text of the regulations. It is only reasonable to assume that insurers will include

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			provision of language assistance services and how patients can access those services.	operational information regarding how patients can access language interpreter services in their notification to providers. This level of micro-management is not necessary for regulations.
		Decline	§2538.6 (e) Every health insurer shall notify contracting providers of the insurers process for obtaining interpretation services so the provider can facilitate language services at the time of treatment.	
		Decline	In addition, we are concerned that the DOI not dictate terms of contracts between insurers and providers with respect to LAPs. Section 2538.3(d) mandates that contracts contain implementation language for the health insurer's Language Assistance Program. Since LAPs can be implemented without provider responsibility, any LAP implementation terms should be left to the contracting parties to define. At the same time, if the financial responsibility of the insurer for implementation is delegated, it should be explicitly referenced in the contract. The relevant parts of subsection (d) should be amended to read: . . . Health insurers who directly contract with health care providers or who lease networks of health care providers ~~shall~~ may use these contracts to implement . . . and Health insurers shall retain financial responsibility for the implementation of the Language Assistance Program except to the extent that delegated financial responsibility has been negotiated	Health insurers who directly contract with providers or lease networks of providers shall amend their contracts with providers and networks "as needed" to implement their LAP. The Commissioner has built in flexibility for health insurers regarding how they implement their LAP.

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			separately and incorporated by direct reference into its contract.	
8	**Anthony Wright Health Access**	**No response needed.**	We begin by noting that we are supportive of the proposed regulations. A careful review of the proposed regulatins demonstrates that they are consistent with eh law and are clear as written. In several insances the Department has changed the language to more closely conform to the language in the law. The Department has also removed extraneous requirements from the previous version, or ones that migh have been desireale, bu did not have a foundation in the statute.	Supportive of the revised text of the regulations.
		No response needed.	**Requirement for Interpretation and Translation Services** The Department's final language in this regulation adds clarity regarding the different language requirements for interpretation vs. translation services and they shold be commended for making that distinction…In addition, the clarification regarding the limited circumstances in which a minor/friend/family member can be permitted to interpret is also a significant improvement in regulatiory language, while providing fundamental and yet pragmatic safeguards for the patient.	Supportive of the revised text of the regulations.
		Decline	**Vital Documents** The listing of vital documents should be expanded to include the actual grievance form itself. This would ensure that low English-proficient patients are equally able to exercise their rights by filing complaints using a form in a language other than English.	We believe that the current language of this subsection would require the translation of the form to be filed for a complaint because the language states: "Notices pertaining to…and the right to file a complaint or appeal;" and the form to be filled out by the complainant "pertains" to the right to file a complaint or appeal.

CALIFORNIA DEPARTMENT OF INSURANCE
Response to Public Comments
SB 853 - Health Care Interpreter Regulations
2nd Comment Period
Ending 11/9/2006

#	Person Submitting Comment	Action Taken	Summary of Comments/Issues Submitted	CDI Response
9	**Conrad Llaguno Kaiser Permanente**		Delineated below are our comments pertaining to the revised text of the Proposed Regulations.	
		No response needed.	1. **§2538.2 Definitions** We noted that the text indicating individual insurance policies and certificates have been deleted from the definition of "Vital Documents." We thank you for your reconsideration of this text and the resulting deletion.	Supportive of the revised text of the regulations.
		No Response needed.	**2. §2538.3 Language Assistance Program** The implementation date under the insurance regulations is different from that of the effective date of the proposed regulations of the Department of Managed Care. Having a single effective date for both sets of regulations provides simplicity and thereby less confusion as to which set is effective when. To the extent that health care products, which are underwritten by insurance companies, are either collateral to or in support of HMO plans, the later effective date of January 1, 2009 is appropriate.	The text of this section [§2538.3(a)] was not amended by the revised text. Therefore, no response is required. This provision also allows the Commissioner to grant flexibility in compliance based on a Plan's challenges and this would include the implementation date.
		Accept in part. Decline in part.	**3. §2538.6 Individual Access to Oral Interpretation Services.** As to the use of minor as interpreters, we recommend that language from the DMHC Proposed Regulation be modified to incorporate into the insurance regulations. Such language is as follows:	Declined as to specific wording suggested. However, the changes made in the second revision of the regulations accomplish exactly what the commenter is seeking.

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			"A requirement that qualified interpretation services be offered to LEP insureds, at no cost to the insured, at all points of contact, including when an insured is accompanied by a family member or friend who can provide interpretive services. The offer of a qualified interpreter, and the insured's refusal, if interpretation services are decline, shall be documented in the medical record or plan file, as applicable."	
10	**Eric DuPont Metropolitan Life Ins. Co.**	**Decline**	**§2538.2(b) Health Insurer** Rather than define "Health insurer" in § 2538.2 of the regulation, it appears that the Department intends to refer back to section 106 of the California Insurance Code in § 2538.1 of the Proposed Regulation. While this streamlines the Proposed Regulations and avoids potential confusion with the definition, there remains a need to distinguish between limited scope dental insurance and comprehensive medical/hospital/surgical insurance. The latter we believe is what is intended to be covered under the definition of "Health insurer" in CIC § 106, the former we believe is not expressly and entirely covered by this definition. MetLife Dental urges you to recognize the difference between standalone limited scope dental insurance and scope dental insurance and comprehensive medical/hospital/surgical insurance by limiting the application of the Proposed Regulations and the requirements for implementation of a LAP for standalone limited scope dental insurance to covered surgical benefits.	The Department's reading of this section does include dental insurance plans. This is a relatively recent addition to the Insurance Code. Note specificly the excluded types of insurance plans and dental does not appear. If the Legislature intended to exclude dental insurance from this broad definition of health insurance, it would have been listed as an exclusion. The Commissioner has built into these regulations flexibility for health insurers to develop their LAP to best suit their needs.

CALIFORNIA DEPARTMENT OF INSURANCE
Response to Public Comments
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		Decline	**Vital Documents** The documents identified as Vital documents in items (1) – (6) of § 2538.2 (1) are provided for in and are consistent with CIC §§ 10133.8 and 10133.9. Proposed Regulation § 2538.2(1)(7) provides that [a] matrix of the categories of health insurance benefit is a Vital document. MetLife Dental does not believe such language is consistent with CIC §§ 10133.8 and 10133.9, as it does not appear to be contained in these statutes. Further, it is not clear to us what is meant by a matrix of the categories of health insurance benefits, MetLife Dental is not aware that such a document exist within our enterprises and believes that it may be required to create such a vital document from scratch in order to comply with the Proposed Regulation. Based on the above, MetLife dental urges the Department to remove the "matrix" requirement from the Proposed Regulations or make it apply only when such a document exist for reasons other that compliance with the Proposed Regulations.	This is probably the single most important document for the dental insured. It provides an easier to understand layout of exactly what the insurance plan covers and does not cover. It supplies exactly what the insured's out of pocket payments will be for different types of services. In dental insurance, this is the lifeblood of benefits documents typically distinguishing between preventive, restorative and major procedures which are typically covered by the plan at different co-insurance levels. This matrix of benefits document would be even more crucially important in limited benefit plans since it would put consumers on notice of exactly which benefits are NOT covered.
		Accept in part. Decline in part.	**Annual Notice** Proposed Regulation § 2538.3 (c) has been amended to require that health insurers shall provide notice developed by the Commissioner to their insureds on an annual basis. MetLife Dental requests that this annual notice requirement be reconsidered. Such annual notice will be costly to our insureds and MetLife Dental believes, will have little impact on promoting awareness of a LAP. Internal estimates are that providing such	The regulation is permissive " The Commissioner *may..*" The Commissioner has broad authority under Section 10133.8 (a) to adopt regulations to implement this statute and something as minor as a State notice to be passed on to insureds advising them of their rights to language assistance does not require a specific statutory mandate.

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			notice will come at a cost of at least $100.000 per year for MetLife Dental. Cost effective alternatives MetLife Dental believes will provide notification to those most likely to utilize the services of a LAP would be to include notice with the survey required by the proposed Regulation or with an insured's initial enrollment in an insurance plan. MetLife Dental request that the proposed Regulations be amended to reflect either of these suggested alternatives for providing notice of a LAP in place of an annual notice.	This type of notice could easily be included in any other communication the insurer sends to its insureds. Since most policies are renewed annually, this notice requirement which can be incorporated into any other mailing, including a payment notice, is not burdensome and furthers the goal of the regulations in making LEP insureds aware of such services.
		Decline	**Networks** Proposed Regulation §2538.3(d) has been amended to require insurer oversight over network implementation of LAPs. MetLife Dental does not believe that there is any statutory authority for this requirement. CIC § 10133.8 (e) requires 'services, verbal communications and written materials provided by or developed by the health insurers that contact for alternative rates of payment with providers shall comply with the standards developed under this section. Considering that the LEP assistance law governing insurers mirrors significantly the managed health care law on this issue, we do not believe that the omission of "require compliance" from § 10133.8 (e) was inadvertent. As a result, the statutory requirement for health insurers is to make available the interpretation and translation material, rather that require insurers to monitor their providers for compliance.	Since an increasing number of dental insurance plans rely on dental PPO Networks, either directly contracted or leased, it is imperative that these regulations address this possibility. Ultimately, the requirement for LAP services is imposed on the insurer. If the insurer elects to use a dental network to provide the services covered by the insurance plan, it is incumbent on the plan to make sure that those provider contracts address the question of LAP services and how they will be provided. Note that the regulations do not dictate the terms of the contract provisions, only that it be addressed in the contract between the insurer and the network provider.

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		Decline in part. Accept in part.	MetLife Dental requests that the proposed Regulations be further amended to more closely follow the statutory authority by removing the requirement for insurer oversight over network implementation of LAPs. **Needs Assessment** Proposed Regulation §2538.4(a) has been amended to require that insurers survey and "assess the linguistic needs of each insured (emphasis added) MetLife Dental requests clarification of what is intended by the addition of the word "each" and also notes that "insured" is not defined in the regulation. MetLife Dental considers the insured in a group plan to be the employee or group member, not the employee or member's dependents or other covered individuals who may also receive dental benefit coverage under the employee or member's certificate. MetLife Dental believes that standalone limited scope dental insurers will receive accurate data on the language needs of our total insured population in group plans simply by surveying the employee or group member. Further, if the Department's intent is that each dependent of an employee or group member or other covered individuals be considered separately, this would dramatically increase the cost of the needs assessment required by the Proposed Regulation, as well as the implementation of the LAP. MetLife Dental urges the Department to clarify what is meant by "insured" in the Proposed Regulation, specifically that insured in a group insurance setting is considered the employee or group member.	The statute requires "individual access to interpretation services" by insureds in accessing health care. The insured group is made up of individuals. Each of these individuals speaks a language. For purposes of the needs assessment as well as providing language assistance, the insurer may not assess the needs of the "group" to the arbitrary exclusion of certain individual insureds. The Legislative intent was to make sure that each insured's language needs be included in the insurer's needs assessment. The Commissioner has provided flexibility in the regulations for insurers to survey using a variety of methods, however, without individual language preferences being known, appropriate individual interpretation services will be difficult to provide. Some insurers are already including in their policies a statement regarding access to language assistance services.

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		Decline	**Culture** Proposed Regulation §2538.6 (d) would require "sensitivity to the LEP person's culture" and §2538.7 (c) would require that insurers report on "internal policies and procedures related to cultural appropriateness" (emphasis added) MetLife Dental notes that the term "culture" is not used in CIC § 10133.8 and 10133.9. Further, the Department has not defined "culture" in the Proposed Regulations. MetLife Dental suggests that the inclusion of "culture" in the regulations is not consistent with the intent of CIC §§. 10133.8 and 10133.9 and has the potential for unnecessary confusion in the implementation of LAPs. MetLife Dental suggests that the Department either eliminate the use of "culture" in the Proposed Regulation (which MetLife Dental believes would be consistent with the statutory authority) or provide a definition of the term that will reduce potential for confusion.	While "culturally competent" has been deleted from the regulation, "taking the cultural and social context into account" has not. The legislative history cited specifies the concept of "cultural competence" only. This term has been removed. The remaining uses of the words 'culture' or 'cultural' are descriptive with respect to a part of the remaining regulation. This word carries its everyday meaning in these regulations and is not intended to be overinterpreted as this commenter suggests.
		No response needed.	**Effective Date** MetLife Dental further suggest that the January 1, 2008 effective date for implementing a compliant LAP does not provide enough time considering the enormity of the task of developing such a compliant program. MetLife Dental estimates that properly surveying insureds, compiling the information received, and designing a LAP will take more that a year to complete. Further, a January 1, 2009 implementation date will be	The text of this section [§2538.3(a)] was not amended by the revised text. Therefore, no response is required. This provision also allows the Commissioner to grant flexibility in compliance based on a Plan's challenges and this would include the implementation date.

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			consistent with that set in the DMHC proposed regulation. Therefore, MetLife Dental suggests the date for developing and implementing a compliant LAP be amended to January 1, 2009.	
11	**Kris Hathaway National Assoc. of Dental Plans (NADP)**	**No response needed.**	**Recommendation 1 - Section 2538.2 Definitions: (a)** NADP would suggest deleting race and ethnicity from the "Demographic profile" definition for several reasons: • The gathering of this information is not required by the statute, and would add an enormous cost burden as companies would have to make IT adjustments by adding questions, data fields and other system requirements necessary to capture such information for so many millions of Californians. • The statute's clear intent was to address language barriers in the health care field; not to gather information above and beyond the preferred language of an LEP insured. Suggested Language: "Demographic profile" means, at a minimum, primary/preferred spoken and written language of the insured.	The text of this section [§2538.2(a)] was not amended by the revised text. Therefore, no response is required.
		No response needed.	**Recommendation 2 - Section 2538.2 Definitions, Vital Documents (o)** NADP would recommend altering the definition of Vital Documents so that health insurers have a complete understanding of the specific documents that are expected to be translated. Suggested Language: "Vital Documents" includes but is not limited to the following documents when produced by the health insurer…"	The suggested language is the language of the revised text. No other suggestion was made.

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		Decline	**Recommendation 3 - Section 2538.2 Vital Documents (e)(7):** We recommend the deletion of this new item, as a "matrix" is not included in the authorizing statute. Further, there are distinct concerns regarding how this will be applicable to specialized plans for several reasons: --Dental plans do not currently submit a 'matrix' type document to the Department of Insurance. Many specialized plans would need to craft this paper as an entirely new document just to abide by this specific regulation. It is not considered a vital document within the dental benefits industry. --The matrix as defined, seems to go directly against what is stated in the statute in Section 2, 13607.04 (b)(1)(B)(vi) "Translated documents shall not include a health care service plan's explanation of benefits or similar claim processing information that is sent to enrollees, unless the document requires a response by the enrollee." --We would note that the statute dictates the definition of vital documents and clearly states that it shall not exceed the federal CLAS standards, which does not include such a matrix.	This is probably the single most important document for the dental insured. It provides an easier to understand layout of exactly what the insurance plan covers and does not cover. It supplies exactly what the insured's out of pocket payments will be for different types of services. In dental insurance, this is the lifeblood of benefits documents typically distinguishing between preventive, restorative and major procedures which are typically covered by the plan at different co-insurance levels. This matrix of benefits document would be even more crucially important in limited benefit plans since it would put consumers on notice of exactly which benefits are NOT covered. The matrix does not refer to an EOB or claims processing information. This requirement is authorized by California Insurance Code section 10133.8(b)(3)(B)(iii) that states, "Letters containing important information regarding eligibility or participation criteria" are vital documents required to be translated by the insurer.
		Decline	**Recommendation 4 - Section 2583.3 Language Assistance Program (c)** NADP would recommend deleting, or in the alternative, changing the new addition of including a Commissioner's notice to enrollees, by way of an	The regulation is permissive " The Commissioner *may..*" The Commissioner has broad authority under Section 10133.8 (a) to adopt regulations to implement this statute

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			insurer's mailing, for several reasons: --There is no statutory authority behind this request. --The majority of specialized plans do not send out mailings on an annual basis. To mandate a separate mailing on an annual basis would increase the cost of this already expensive regulation. --These costly mailings are duplicative, as health insurers are required to do the same notice to their enrollees, leading to redundancy and no additional consumer protection. In the same section, the regulations state; "Health insurers shall develop a written notice that discloses the availability of language assistance services to insureds and explain how to access those services." Suggested Language: "…The Commissioner may develop a notice advising LEP insureds of the availability of language assistance services and how to access those services. Health insurers shall provide the notice developed by the Commissioner to their LEP insureds either electronically on their website or included in LAP related mailings to the LEP insureds on an annual basis.	and something as minor as a State notice to be passed on to insureds advising them of their rights to language assistance does not require a specific statutory mandate. This type of notice could easily be included in any other communication the insurer sends to its insureds. Since most policies are renewed annually, this notice requirement which can be incorporated into any other mailing, including a payment notice, is not burdensome and furthers the goal of the regulations in making LEP insureds aware of such services.
		Decline	**Recommendation 5 - Section 2583.3 Language Assistance Program (d) & §2538.7 Health Insurer Monitoring Evaluation & Reporting (a)** The inclusion of networks in the above sections needs to be removed from the regulation as it was not the legislative intent of the statute. NADP advocates the comments as submitted by the Association of California	Since an increasing number of dental insurance plans rely on dental PPO Networks, either directly contracted or leased, it is imperative that these regulations address this possibility. Ultimately, the requirement for LAP services is imposed on the insurer. If the insurer elects to use a dental network to

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			Life & Health Insurers regarding this issue, as they point out several key statutory concerns, including: --The statute reflects that managed care products operate differently than PPO type plans, and did not include these types of contracts, as they are unenforceable by the insurer. --LEP insureds can utilize in and out of network providers in PPO/Indemnity products, implementing LAP procedures through the providers are virtually impossible. NADP is especially concerned regarding this new language as networks are a key component to the dental benefits industry; by requiring that all individual contracts be reviewed and amended could potentially make diminishing dental networks unworkable in California, especially in rural areas.	provide the services covered by the insurance plan, it is incumbent on the plan to make sure that those provider contracts address the question of LAP services and how they will be provided. Note that the regulations do not dictate the terms of the contract provisions, only that it be addressed in the contract between the insurer and the network provider.
		Decline	**Recommendation 6 -** Section **2538.4 Needs Assessment of Insured Population (a)** NADP would recommend including the language below regarding language assessments to increase the methodology choices for health insurers.. Flexibility is the core of allowing health insurers to work appropriately within each plan design. Suggested Language: "…Health insurers may utilize a variety of methods, including census data, client utilization data from third parties, data from community agencies, third party enrollment processes, and statistically valid methods for population analysis. Health insurers may also make use	The revised text deleted the following language: "All survey materials shall be printed in multiple languages, as defined." This comment does not address the changes to the revised text but rather addresses other language.

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			of survey methods, including, but not limited to, the use of existing enrollment and renewal processes, newsletters, or other mailings…"	
		Decline	**Recommendation 7 - Section 2538.6 Individual Access to Oral Interpretation Services (c)** NADP would recommend the **deletion of (c)** in its entirety, as it discourages the use of family members as interpreters. This issue has been heavily debated in the California legislature, and until this issue is resolved in the legislature, regulatory agencies should not write law that has not been authorized by the legislature.	The Commissioner has modified the language to delete "prohibited" and insert "strongly discourage" regarding the use of minors as interpreters. Clarifies the distinction between the use of a minor in an emergency and non-emergency situation. This change was made to ensure that an adult insured would have access to interpretation if their only choice, after being offered a qualified interpreter at no cost, is to use a minor as an interpreter. The statute is silent regarding the details of "individual access to interpretation services". In order to effectuate the purpose of this statute, it is necessary to describe in detail some of the issues that are key to providing this service to LEP insureds such as the use of minor children as interpreters. The development of policies and procedures as proposed in these regulations is a quality assurance measure that will protect individuals, including minor children, from the negative consequences and adverse effects of being inappropriately used as interpreters for patients seeking emergency and non-emergency medical services. The Commissioner has carefully considered the various opinions

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				and positions regarding this issue and has determined that the use of minors as interpreters should be strongly discouraged but not prohibited.
		No response needed.	**Recommendation 8 -** Section **2538.8 Department of Insurance Reporting** NADP would recommend the delay of the DOIs report to the Legislature to allow additional time needed for completion of the LAP by health insurers. Even though the statute lists January 1, 2008 as the due date, in the same section SEC.4, Section 10133.8 (f), it reads; "…The commissioner may also delay or otherwise phase in implementation of the standards and requirements in recognition of the costs…" The date, 1/1/2009 would correlate with the DMHC deadlines, making it easier for health insurers that also operate Knox-Keene licensed plans, to implement their LAP programs within the same time frame. Aligning the effective dates for health insurers and Knox-Keene licensed plans will reduce confusion for consumers, employers who offer both types of plans to their employees, and providers who contract with insurers and health plans. Suggested Language: "Beginning on January1, 20098, the Department shall report biennially to the Legislature regarding health insurer compliance..."	The text of this section [§2538.3(a)] was not amended by the revised text. Therefore, no response is required.

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